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AND
BRIEFS

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IN THE

Supreme Court of the United States

RICHARD ARMSTRONG, ET AL.,
Petitioners,

v.

EXCEPTIONAL CHILD CENTER, INC., ET AL.,
Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

BRIEF FOR THE AMERICAN NETWORK OF COMMUNITY OPTIONS AND RESOURCES, THE AMERICAN HEALTH CARE ASSOCIATION/ NATIONAL CENTER FOR ASSISTED LIVING, THE NATIONAL COMMUNITY PHARMACISTS ASSOCIATION, THE AMERICAN PHARMACISTS ASSOCIATION, AND AMERICA'S ESSENTIAL HOSPITALS AS *AMICI CURIAE* SUPPORTING RESPONDENTS

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QUESTION PRESENTED

Whether the Supremacy Clause (U.S. Constitution, art. VI, cl. 2) affords Medicaid providers a private right of action to enforce 42 U.S.C. § 1396a(a)(30)(A) through suits against state officials.

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INTEREST OF *AMICI CURIAE*[1]

Amici curiae ("*Amici*") are national organizations whose members participate in state Medicaid programs across the country as providers of covered services. These providers are dependent upon Medicaid reimbursement as a means of assuring that they can provide both access to and quality of services for program beneficiaries. As such, they are keenly interested in and significantly affected by issues relating to the adequacy of Medicaid rates. The six *Amici* are:

- The American Network of Community Options and Resources ("ANCOR");
- The American Health Care Association/ National Center for Assisted Living ("AHCA/NCAL");
- The National Association of Chain Drug Stores ("NACDS");
- The National Community Pharmacists Association ("NCPA");
- The American Pharmacists Association ("APhA"); and
- America's Essential Hospitals ("AEH").

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[1] Pursuant to Supreme Court Rule 37.6, counsel for *amici curiae* represents that no counsel for a party authored this brief in whole or in part and that none of the parties or their counsel, nor any other person or entity other than *amici*, their members, or their counsel made a monetary contribution intended to fund the preparation or submission of this brief. Counsel for *amici* also represents that all parties have consented to the filing of this brief, and letters reflecting their blanket consents to the filing of *amicus* briefs have been filed with the Clerk.

A brief description of each *Amici* follows:

ANCOR is a national, nonprofit trade association representing 46 state provider associations and more than 800 individual private community providers of long term care supports and services for individuals with significant disabilities. Founded nearly 45 years ago, ANCOR's members serve over 400,000 individuals with disabilities, primarily intellectual and developmental, to live and work in home community settings. Medicaid is the primary payer for these services, and providers that furnish them are almost exclusively dependent upon Medicaid revenues to cover their costs. ANCOR is the leading resource and advocate for these providers in matters before Congress and the Administration, communicating and promoting their essential role in delivering critical lifespan supports and services to enable people with disabilities to realize the promise of the Americans with Disabilities Act.

AHCA/NCAL is the nation's largest association of long-term and post-acute care providers, representing the interests of over 12,000 nonprofit and for-profit facilities, many of which participate in Medicaid and serve residents who are beneficiaries of the program and dependent upon it to pay for their care. AHCA/NCAL members are dedicated to improving the delivery of professional and compassionate care to more than 1.5 million frail, elderly, and disabled citizens who live in nursing care centers, assisted living communities, and homes for individuals with intellectual and developmental disabilities. AHCA/NCAL advocates for quality care and services for these at risk Americans. In order to ensure the availability of such services, AHCA/NCAL also supports the continued vitality and financial feasibility of the

long-term and post-acute care provider community through adequate compensation by payers, including Medicaid, for the care these providers render. In this vein, the providers represented by AHCA/NCAL depend on Medicaid for large portions of their total revenues. In 2013, for example, 56% of their bed days were billed to Medicaid and, thus, adequate reimbursement rates are vital to their ability to provide quality care to the resident patients they serve.

NACDS is a 501(c)(6) nonprofit trade association. Its mission includes advancing the interests and objectives of chain community pharmacies, including highlighting their role as providers of health care services. NACDS represents 125 chain community pharmacy companies, including traditional drug stores, supermarkets, and mass merchants with pharmacies—from regional chains with four stores to national companies. These members operate more than 40,000 pharmacies in the United States and provide jobs for more than 3.8 million employees, including 175,000 pharmacists. NACDS members fill more than 2.7 billion prescriptions annually, of which a significant number are for Medicaid beneficiaries. As committed and critical members of the patient care team needed to ensure positive health care outcomes for Medicaid beneficiaries, NACDS and its members take seriously their responsibility to work to assure access of beneficiaries to their local community pharmacies and to advocate for fair compensation of these pharmacies for their services.

NCPA was founded in 1898 as the National Association of Retail Druggists and is a nonprofit trade association organized under the laws of Virginia. NCPA represents the interests of America's

community pharmacists, including the owners of nearly 23,000 independent community pharmacies. Collectively, they represent an $88.8 billion per year health care marketplace, dispense nearly 40% of all retail prescriptions, and employ more than 300,000 individuals, including over 62,000 pharmacists. NCPA's mission is to represent the interests of its member pharmacies and the health and well-being of the public they serve, including Medicaid beneficiaries. In that respect, in 2013, Medicaid covered 17% of all prescriptions dispensed at the average independent community pharmacy and, on *a per pharmacy basis*, accounted for more than $610,000 in annual revenues and 10,000 prescriptions per year.

APhA is the first-established and largest association of pharmacists in the United States. It originated in 1852 as the American Pharmaceutical Association and is now a 501(c)(6) organization, consisting of more than 62,000 practicing pharmacists, pharmaceutical scientists, student pharmacists, pharmacy technicians, and others interested in advancing the profession. APhA is dedicated to helping all pharmacists improve both medication use and patient care. Its members provide care in all practice settings, including community pharmacies, hospitals, long-term care facilities, community health centers, managed care organizations, hospice, and the uniformed services. Medicaid beneficiaries constitute a significant segment of the patients served by APhA members in these various settings.

AEH is a 501(c)(6) nonprofit trade association and a champion for hospitals and health systems dedicated to high-quality care for all. Its membership comprises more than 250 essential hospitals and health systems across the country which predominantly serve

patients covered by public programs (*e.g.*, Medicare and Medicaid) and the uninsured. Filling a safety net role in their communities, members of AEH furnish over a quarter of their inpatient and outpatient services to Medicaid patients. Despite its members' long-standing commitment to treating Medicaid and other vulnerable populations, increased Medicaid volumes at reduced or insufficient rates threaten their long-term financial viability and their ability to serve Medicaid recipients adequately. Thus, AEH and its members have a strong interest in the proper administration and strict enforcement of statutory requirements of the Medicaid Act.

All of the *Amici* strongly support Respondents' contention that 42 U.S.C. § 1396a(a)(30)(A) is privately enforceable by Medicaid providers and that the existence of such a private right of action is indispensable to ensuring compliance with the requirements of the Medicaid Act. They also fully endorse Respondents' argument that this provision is privately enforceable under the Supremacy Clause. This Court should be under no illusions that the review of proposed Medicaid state plan amendments and proposed waivers by the United States Department of Health and Human Services ("HHS"), HHS's general authority to monitor the operation of state plans in cases—like this one—where there are no proposed plan amendments, or state efforts at self-policing their own compliance with federal law suffice to assure such compliance and to make provider and beneficiary litigation unnecessary and superfluous. Decades of case law and the history of the Medicaid program resoundingly refute such notions. HHS lacks the time, staff, and resources to be the sole cop on the Medicaid beat, and the states' own self-interests create an insurmountable hurdle to their

willingness or ability to regulate themselves meticulously.

Providers have been permitted to litigate Medicaid rate issues for almost four decades, and there is simply no evidence that such actions have been counterproductive or destructive. To the contrary, Medicaid providers and beneficiaries have enjoyed a sizeable degree of success in the courts when states exceed the bounds of the Medicaid Act. There is and has been no pattern of baseless or frivolous litigation. In fact, providers and beneficiaries generally view litigation as a last resort when all other options have been exhausted. Most importantly, the ability to bring these cases is essential to assuring that Medicaid rates are sufficient to enlist significant numbers of providers into the program, creating needed access to health care services for the Medicaid population in accordance with the Medicaid Act.[2]

SUMMARY OF ARGUMENT

The Court granted *certiorari* in this case to decide whether the Supremacy Clause furnishes Medicaid providers with a private right of action to enforce 42 U.S.C. § 1396a(a)(30)(A) (2013)—a Medicaid Act provision requiring that program rates meet certain

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[2] Detailed discussion of a number of these points is beyond the narrow scope of this brief but are well and fully addressed in Respondents' brief and those of other supporting *amici curiae*. *See generally* Sean Jessee, *Fulfilling the Promise of the Medicaid Act: Why the Equal Access Clause Creates Privately Enforceable Rights*, 58 Emory L.J. 791 (2009); Abigail R. Moncrieff, *Payments to Medicaid Doctors: Interpreting the Equal Access Provision*, 73 U. Chi. L. Rev. 673 (2006); Malcolm J. Harkins III, *Be Careful What You Ask For: The Repeal of the Boren Amendment and Continuing Federal Responsibility For Cost Effective Quality Nursing Facility Care*, 4 J. Health Care L. & Pol'y 159 (2002).

standards. Ironically, this Court has never decided the question of whether that provision may be privately enforced through 42 U.S.C. § 1983. The case law on that issue in the federal appeals courts is split and reflects varying and shifting views. Many of these views are premised on this Court's most recent precedents and the evolving tests it uses as to whether there are private rights of action under § 1983 in other contexts.

Congress, however, has mandated that courts use the standards established before 1992 to determine, in cases like this one, whether there is a private right of action under the Supremacy Clause or through § 1983 to enforce Social Security Act provisions. 42 U.S.C. §§ 1320a-2; 1320a-10 (2013). Although these particular mandates were not referenced by the District Court or the Ninth Circuit in this case, they have been discussed in other Ninth Circuit precedent. Unfortunately, that precedent gave off-handed and insufficient recognition of these mandates, using flawed reasoning and misunderstanding the case law in a way that would render these congressional mandates a nullity.

As a consequence, although *Amici* strenuously support affirmance of the Ninth Circuit's decision on its stated grounds, if this Court is not disposed to conclude that the Supremacy Clause may be used as a basis for private enforcement of the equal access provision, it should remand the case to the Ninth Circuit for full briefing and oral argument about the implications of these mandates and how they apply to this case. Doing so would enable this Court to avoid unnecessarily deciding an issue of constitutional dimension. It would also effectuate congressional intent as to how private rights of action under the

Supremacy Clause and § 1983 should be determined in Social Security Act cases. Finally, it would promote the commonsense and rational notion that judicial decisions in these cases must necessarily take into account what the framers of the particular legislation knew and intended at the time of enactment.

ARGUMENT

I. BACKGROUND

Under 42 U.S.C. § 1396a(a)(30)(A), otherwise known as the "equal access" provision, a state Medicaid plan must:

> [P]rovide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan. as may be necessary to safeguard against unnecessary utilization of such care and services and *to assure that payments are consistent with efficiency, economy, and quality of care* and are *sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area.* (Emphasis added.)[3]

Typically, issues concerning whether a federal enactment may be judicially enforced by a private party turn upon one of three general inquiries that

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[3] Significantly, this provision establishes two separate and independent standards regarding Medicaid payments to fee-for-service providers: (1) consistency with efficiency, economy, and quality of care; and (2) sufficiency to assure provider enlistment at the levels needed to afford equal access for Medicaid beneficiaries to care.

must be answered at the outset prior to the application of any principles that govern whether a private right of action exists in a specific case. First, does the particular provision itself or the legislation of which it is a part confer such a right of action either expressly or impliedly? *E.g.*, *Cort v. Ash*, 422 U.S. 66, 78 (1975); *J.I. Case Co. v. Borak*, 377 U.S. 426, 432 (1964). Second, if it does not, may cases be brought to enforce the provision pursuant to 42 U.S.C. § 1983?[4] *E.g.*, *Maine v. Thiboutot*, 448 U.S. 1, 9-10 (1980). Third, if § 1983 does not function as a basis for private enforcement, does the Supremacy Clause allow for a private right of action?[5] *E.g.*, *Douglas v. Indep. Living Ctr. of S. Cal., Inc.*, ___ U.S. ___, 132 S. Ct. 1204 (2012) (granting *certiorari* to decide whether the equal access

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[4] 42 U.S.C. § 1983 (2013) reads:

> Every person who, under color of any statute, ordinance, regulation, custom, or usage, of any State or Territory, subjects or causes to be subjected, any citizen of the United States or other person within the jurisdiction thereof to the deprivation of any rights, privileges, or immunities secured by the Constitution and laws shall be liable to the party injured in an action at law, suit in equity, or other proper proceeding for redress.

[5] The Supremacy Clause (U.S. Constitution, art. VI, cl. 2) provides:

> This Constitution and the Laws of the United States which shall be made in Pursuance thereof; and all Treaties made, or which shall be made under the authority of the United States, shall be the Supreme Law of the Land; and the Judges in every State shall be bound thereby, anything in the Constitution or Laws of any State to the contrary notwithstanding.

provision may be privately enforced pursuant to the Supremacy Clause but the case was decided on alternative grounds).

This Court has previously determined that the Social Security Act (of which the Medicaid Act is a part) does not create an express or implied right for private parties to seek judicial enforcement of its provisions. *E.g.*, *Edelman v. Jordan*, 415 U.S. 651, 674–75 (1974). Thus, the first of the overall three private right of action inquiries is not met here.

Although the second general inquiry relating to § 1983 has generated a significant amount of inconsistent, varying, and fluctuating case law in the context of the equal access provision, this Court has never specifically addressed the issue of whether 42 U.S.C. § 1396a(a)(30)(A) may be privately enforced by either or both Medicaid providers or beneficiaries through actions under § 1983. Rather, the *assumption* appears to be that, under the private right of action criteria enunciated for § 1983 cases in *Gonzaga Univ. v. Doe*, 536 U.S. 273 (2002), this Court would not find that the equal access provision may be privately enforced in this manner. Nonetheless, the Circuit case law on this point includes:

> *First Circuit*: *Long Term Care Pharmacy Alliance v. Ferguson*, 362 F.3d 50, 57–60 (1st Cir. 2004) (holding there is no private right of action for providers and, impliedly, none for beneficiaries based upon *Gonzaga*), overturning *Visiting Nurse Ass'n of N. Shore, Inc. v. Bullen*, 93 F.3d 997 (1st Cir. 1996), *cert. denied*, 519 U.S. 1114 (1997) (pre-*Gonzaga* decision) (holding that providers have such a right of action and implying that beneficiaries do as well).

Second Circuit: *New York Ass'n of Homes and Servs. for the Aging v. DeBuono*, 444 F.3d 147, 148 (2d Cir. 2006) (per curiam) (affirming the district court decision based on *Gonzaga*, finding no private right of action for providers).

Third Circuit: *Penn. Pharmacists Ass'n v. Houstoun*, 283 F.3d 531, 537-42 (3d Cir. 2002) (*en banc*) (6-5 pre-*Gonzaga* decision) (relying in part on *Blessing v. Freestone*, 520 U.S. 329 (1997), to find no private right of action for providers), *overruling Rite Aide of Penn., Inc. v. Houston*, 171 F.3d 842, 850 n.7 (3d Cir. 1999) (finding providers had such a right of action).

Fifth Circuit: *Walgreen Co. v. Hood*, 275 F.3d 475, 477-78 (5th Cir. 2001) (pre-*Gonzaga* decision) (concluding, based on *Blessing*, that providers do not have a private right of action); *Evergreen Presbyterian Ministries, Inc. v. Hood*, 235 F.3d 908, 924-32 (5th Cir. 2000) (pre-*Gonzaga* decision) (holding, also predicted in part on *Blessing*, that beneficiaries, but not providers, have a right of action).

Sixth Circuit: *Westside Mothers v. Olszewski*, 454 F.3d 532 (6th Cir. 2006) (holding, based on *Gonzaga* and *Blessing*, no private right of action for beneficiaries or providers), overturning *Westside Mothers v. Haveman*, 289 F.3d 852 (6th Cir. 2002) (pre-*Gonzaga* decision) (holding that providers have a private right of action).

Seventh Circuit: *Methodist Hosp., Inc. v. Sullivan*, 91 F.3d 1026, 1029 (7th Cir. 1996) (pre-*Gonzaga* decision) (ruling that providers have a private right of action.)

Eighth Circuit: *Pediatric Specialty Care, Inc. v. Arkansas Dept. of Human Servs.*, 443 F.3d 1005, 1013-16 (8th Cir. 2006) (holding that providers and beneficiaries both have a private right of action); *Pediatric Specialty Care, Inc. v. Arkansas Dept. of Human Servs.*, 364 F.3d 925, 930 (8th Cir. 2004) (holding the same); *Pediatric Specialty Care, Inc. v. Arkansas Dept. of Human Servs.*, 293 F.3d 472, 477-78 (8th Cir. 2002) (pre-*Gonzaga* opinion) (holding to the same effect); *Arkansas Medical Soc'y, Inc. v. Reynolds*, 6 F.3d 519, 523-28 (8th Cir. 1993) (pre-*Gonzaga* decision) (coming to the same result).

Ninth Circuit: *Sanchez v. Johnson*, 416 F.3d 1051, 1055-62 (9th Cir. 2005) (applying *Blessing* and *Gonzaga* to conclude that neither providers nor beneficiaries have a private right of action); *Orthopedic Hosp. v. Belshe*, 103 F.3d 1491 (9th Cir. 1997) (ruling in favor of providers on the merits of an equal access claim without addressing the private right of action issue).

Tenth Circuit: *Oklahoma Chapter of the Am. Acad. of Pediatrics v. Fogarty*, 472 F.3d 1208, 1215 (10th Cir. 2007) (concluding that neither providers nor beneficiaries have a private right of action, based on *Mandy R. v. Owens*, 464 F.3d 1139, 1146-48 (10th Cir. 2006) (using *Blessing* and *Gonzaga* to hold the same)).

Eleventh Circuit: *Tallahassee Mem'l Reg'l Med. Ctr. v. Cook*, 109 F.3d 693, 702 (11th Cir. 1997) (pre-*Gonzaga* decision) (ruling that providers have a private right of action).

In sum, seven federal appeals courts—the First, Second, Third, Fifth, Sixth, Ninth, and Tenth Circuits— have ruled that Medicaid providers have no private right of action under § 1983 to sue to enforce the equal access provision. Generally, these courts have relied heavily upon *Gonzaga* and/or *Blessing* to reach those conclusions. At least four of these same Circuits (the First, Third, Sixth, and Ninth) had expressly or impliedly found such a private right of action before effectively reversing themselves based on this Court's more recent decisions. *See* Section II(A), *infra*. Meanwhile, three federal appeals courts—the Seventh, Eighth, and Eleventh Circuits—have found such a right, although the rulings in the Seventh and Eleventh Circuits are pre-*Gonzaga*.

Likewise, the question of whether Medicaid beneficiaries have a private right of action through § 1983 to enforce the equal access provision has also been handled disparately by the Circuits. Three federal appeals courts—the Sixth, Ninth, and Tenth Circuits—have applied *Gonzaga* to determine that there is no such right of action. The Fifth and Eighth Circuits have reached the opposite conclusion, though the Fifth Circuit's decision on that point is pre-*Gonzaga*.

Plainly, although this Court has not decided the issue of whether the equal access provision may be privately enforced through a § 1983 action, its precedents in *Blessing* and *Gonzaga* have, unsurprisingly, had a material bearing on the outcomes of federal appeals court decisions on the issue.

As *Amici* now explain, there is a serious question as to whether determinations that the equal access statute cannot be privately enforced under the Supremacy Clause or through § 1983 can be squared with other congressional enactments and intent.

II. THERE IS SUBSTANTIAL DOUBT WHETHER THIS COURT'S EVOLVING STANDARDS IN PRIVATE RIGHT OF ACTION CASES SHOULD BE APPLIED IN THE CONTEXT OF THE SOCIAL SECURITY ACT

A. Over Time, The Criteria For Ascertaining Private Rights Of Action Have Changed

Tracing the history and the holdings in cases involving the question of whether a particular federal provision may be privately enforced through § 1983 could easily fill one or more editions of even the most ambitious law review journal. Over the years, the standards used to decide that issue have varied and, in recent years, have tightened, making it less likely that a private right of action will be found. A brief and non-exhaustive review of § 1983 case law highlights the evolution of these standards.

In *Thiboutot*, 448 U.S. at 4–8, this Court held that welfare beneficiaries under the Social Security Act had a private right of action to enforce federal law entitling them to benefits. At that time, the Court did not establish elements or tests for determining whether a private right of action existed in a particular case.

A year thereafter, in *Pennhurst State Sch. and Hosp. v. Halderman*, 451 U.S. 1, 28 (1981), the Court cautioned that "the typical remedy for state

noncompliance with federally imposed conditions is not a private cause of action for noncompliance but rather action by the Federal Government to terminate funds to the State." At issue was whether a federal statutory bill of rights for persons with developmental disabilities (42 U.S.C. § 6010) could be privately enforced through § 1983 if their care and treatment violated those rights. The Court held that § 6010 did not confer any substantive rights—it did not "unambiguously" impose an obligation on states to meet those requirements as a condition for the receipt of federal monies. *Id.* at 12–13, 17, 27. Accordingly, because there was no substantive right, the court did not reach the issue of whether there was a private right of action under the section itself or through § 1983 to enforce the terms of § 6010. *Id.* at 28 n.21.

Subsequently, *Golden State Transit Corp. v. City of Los Angeles*, 493 U.S. 103, 105 (1989) examined the question of whether the National Labor Relations Act[6] created certain rights that could be vindicated privately through a § 1983 action. The Court held that it did, explaining that the availability of a § 1983 remedy is conditioned upon a multi-tiered test:

(1) whether the statute creates obligations "sufficiently specific and definite" to be within "the competence of the judiciary to enforce";

(2) whether the statute is intended to benefit the putative plaintiff; and

(3) whether private enforcement is not foreclosed by the statute through either express provision or other specific evidence.

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[6] 29 U.S.C. §§ 151–169.

493 U.S. at 106–108 (quoting *Wright v. Roanoke Redevelopment and Hous. Auth.*, 479 U.S. 418, 432 (1987)).

A year later, the Court applied the *Golden State Transit* criteria to find that Medicaid providers had a private right of action to enforce the so-called Boren Amendment. That provision governed Medicaid rate setting for certain types of providers in terms that are remarkably similar to those found in the equal access provision (efficiency, economy, and quality of care and reasonable access to services by beneficiaries).[7] *Wilder v. Va. Hosp. Ass'n*, 496 U.S. 498, 509–10 (1990).

In *Suter v. Artist M.*, 503 U.S. 347, 350 (1992), the Court reviewed the question of whether provisions of the Adoption Assistance and Child Welfare Act of 1980[8] could be privately enforced under the Act itself or pursuant to § 1983. These provisions mandated reasonable state efforts to curtail removal of children from their homes prior to placement in foster care and to return children to their homes where removal had occurred. *Id.* at 351; *see also* 42 U.S.C. § 671(a). The Court used the tenets in *Golden State Transit* to find that these provisions could not be privately enforced,

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[7] The Boren Amendment, formerly 42 U.S.C. § 1396a(a)(13)(A), was subsequently repealed by the Balanced Budget Act of 1997, Pub. L. No. 105-33, § 4711, 111 Stat. 251, 507. It dealt with Medicaid rates for inpatient hospital services, nursing facility services, and services provided by intermediate care facilities for the mentally retarded—the last of which are now facilities for individuals with intellectual disabilities. Notably, the equal access provision, which remained untouched by Congress when and after the Boren Amendment was repealed, governs Medicaid rate-setting for all types of Medicaid fee-for-services providers. 42 U.S.C. § 1396a(a)(30)(A).

[8] 42 U.S.C. §§ 620–628b; 670–679c (1989).

reasoning that the statutory provisions and their implementing regulations did not represent or provide notice to the states as to what failures or inactions on a state's part could trigger loss of federal funds. *Id.* at 361–62.

Blessing, 520 U.S. at 332, involved the question of whether custodial parents could privately enforce Title IV-D of the Social Security Act,[9] to assure "substantial compliance" with its requirements. *Id.* The Court found that there was no generalized private right of enforcement under this program and noted that the statutory scheme could not be analyzed on a general basis. Rather, it was necessary to distinguish among the statute's numerous provisions on an individual basis. 520 U.S. at 333. In doing so, the Court stated that, in determining private rights of action under § 1983, three factors must be considered:

(1) whether Congress intended the provision to benefit the plaintiff;

(2) whether the alleged right is sufficiently specific (and not vague or amorphous) so that its interpretation is within judicial competence; and

(3) whether the statute imposes an unambiguous obligation on the state.

Id. at 340–41.[10]

Finally, in *Gonzaga*, 536 U.S. at 276, this Court rejected the contention that provisions of the Family

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[9] 42 U.S.C. §§ 651–669b (1994).

[10] Note that the first two factors are the same as in *Golden State Transit*. The third, however, substitutes an unambiguous state obligation for private enforcement not being foreclosed by the statute.

Educational Rights and Privacy Act of 1974 could be privately enforced under § 1983.[11] Among other things, the Act precludes federal funding to educational institutions that have policies or practices of releasing educational records to unauthorized individuals. *Id.* at 279; *see also* 20 U.S.C. § 1232g(b)(1). In its ruling, the Court acknowledged that some of its opinions might be construed to allow "something less than an unambiguously conferred right" as being enforceable under § 1983, and it expressly referenced *Blessing* as an example. *Id.* at 282. It then emphasized that only an "unambiguously conferred right" would support a § 1983 cause of action. *Id.* at 283. Further, the Court opined that the discernment of whether such private rights of action exist under § 1983 should not differ from whether they exist in the context of implied rights of action. *Id.* at 283, 285. In other words, both types of situations should be approached using the same inquiries.

In sum, even a casual perusal of the case law reveals that the criteria used to assess whether a private right of action exists to enforce a particular federal provision under § 1983 have changed over time. They have become more stringent and, accordingly, made it more difficult for potential private plaintiffs to establish a private right of action. The Court itself has conceded in *Gonzaga* that its earlier precedent could allow private enforcement of something less than "an unambiguously conferred right" so long as plaintiff fell "within the general zone of interest that the statute is intended to protect," and it cited *Va. Hosp. Ass'n* on that score. *Gonzaga*, 536 U.S. at 283. As reflected below, this trend concerned Congress two decades ago

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[11] 20 U.S.C. § 1232g (1994).

and resulted in legislation designed to establish the terms upon which private right of action cases should be analyzed in the context of the Social Security Act.

B. Congress Intervened To Set The Terms Upon Which Private Right Of Action Cases Should Be Resolved Under The Social Security Act

Two years after this Court's decision in *Artist M.*, Congress passed and President Clinton signed the Improving America's School Act of 1994.[12] Section 555 of that Act is entitled "Effect Of Failure To Carry Out State Plan" and is codified at 42 U.S.C. § 1320a-2. Section 555(a) read:

> In an action brought to enforce a provision of the Social Security Act, such provision is not to be deemed unenforceable because of its inclusion in a section of the Act requiring a State plan or specifying the required contents of a State plan. This section is not intended to limit or expand the grounds for determining the availability of private actions to enforce State plan requirements other than by overturning any such grounds applied in *Suter v. Artist M.*, 112 S.Ct. 1360 (1992), but not applied in prior Supreme Court decisions respecting such enforceability; provided, however, that this section is not intended to alter the holding in *Suter v. Artist M.* that section 471(a)(15) of the Act is not enforceable in a private right of action.

Section 555(b) of that legislation dealt with the "Applicability" of this provision and directs that: "The

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[12] Pub. L. No. 103-382, 108 Stat. 3518.

amendment made by subsection (a) shall apply to actions pending on the date of the enactment of this Act and to actions brought on or after such date of enactment." The date of enactment was October 20, 1994.

The legislative history to the Improving America's School Act of 1994 furnishes insight into what Congress was seeking to achieve through this provision. The conference report to the legislation explains:

> The Adoption Assistance and Child Welfare Act of 1980 amended the Social Security Act to require States to provide in their Title IV-E plans that, in the case of each child, reasonable efforts will be made (a) prior to the placement of the child in foster care, to prevent or eliminate the need for removal of the child from his home, and (b) to make it possible for the child to return to his home (sec. 471(a)(15)).
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> On March 25, 1992, the U.S. Supreme Court held in *Suter v. Artist M.*, that the "reasonable efforts" clause does not confer a federally-enforceable right on its beneficiaries, nor does it create an implied cause of action on their behalf. In rendering its opinion, the Court also stated that although section 471(a) does place a requirement on the States, that requirement "only goes so far as to ensure that the States have a plan approved by the Secretary which contains the 16 listed features."

* * * *

> The provision would amend Title XI of the Social Security Act by adding a new section that reads as follows: "[actual terms of provision then recited] "
>
> The intent of this provision is to assure that individuals who have been injured by a State's failure to comply with the Federal mandates of the State plan titles of the Social Security Act are *able to seek redress in the federal courts to the extent they were able to prior to the decision in Suter v. Artist M.*, while also making clear that there is no intent to overturn the determination in *Suter* that the reasonable efforts clause to Title IV-E does not provide a basis for a private right of action.
>
> The amendment would apply to actions pending on the date of enactment and to actions brought on or after the date of enactment.

H.R. Rep. No. 103-761, at 924, 926 (1994) (Conf. Rep.) (Emphasis added).[13]

As if to underscore its determination in this regard, Congress enacted and President Clinton signed the same provision less than two weeks later as part of the Social Security Act Amendments of 1994.[14] Section 211 of that Act is captioned "Effect Of Failure To Carry Out State Plan" and is codified at 42 U.S.C. § 1320a-10. Section 211(a) is identical to 42 U.S.C. § 1320a-2,

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[13] *Reprinted in* 5 U.S. Code Cong. & Ad. News, 103d Cong., Second Sess. (1994) 2901 at 3255, 3257.

[14] Pub. L. No. 103-432, 108 Stat. 4398.

and Section 211(b) contains the same verbiage as to its applicability.

It seems evident that Congress was seeking to accomplish several objectives in 42 U.S.C. §§ 1320a-2 and 1320a-10. First, Congress sought to overturn the criteria used in *Artist M.*, but not in earlier cases (such as *Golden State Transit* and *Va. Hosp. Ass'n*), to decide private right of action cases. At the same time, it was not seeking to reverse the result itself in *Artist M.* Second, Congress desired that, in Social Security Act cases involving allegations of failure to comply with federal mandates in state plans, the existence of a private right of action under the Supremacy Clause or § 1983 to seek enforcement must be judged by the prevailing precedent prior to *Artist M.* Third, Congress wanted these standards to be applied both to pending Social Security Act cases as of enactment and actions brought thereafter.

Notably, this Court has never cited, let alone analyzed, 42 U.S.C. §§ 1320a-2 and 1320a-10 and their implications. Nor was that done in the instant case by either the District Court or the Ninth Circuit. In one sense, that is not surprising because the Ninth Circuit had already held in *Sanchez v. Johnson*, 416 F.3d at 1062, that, based on *Blessing* and *Gonzaga*, the equal access provision could not be privately enforced under § 1983. Additionally, at that time, the Ninth Circuit made fleeting reference to 42 U.S.C. §§ 1320a-2 and 1320a-10. *Id.* at 1057 n.5. The Ninth Circuit rejected their relevancy, saying that they were "hardly a model of clarity", did not alter the reasoning of *Pennhurst* which was decided prior to *Artist M.*, and—in any event—did not change its obligation to follow *Blessing* and *Gonzaga*. *Id.*

Respectfully, the Ninth Circuit's off-handed analysis is not even facially persuasive. For instance, there is no reference to or discussion of the legislative history of these provisions. Further, the claim that *Pennhurst* remained controlling because it was decided before *Artist M.* is unconvincing. The crucial determinant in *Pennhurst* was that the plaintiffs had formulated their case based on a "bill of rights" provision that was not one of the statutory conditions for receipt of federal funds and did not provide clear notice to the states of their obligations to comply with it or lose federal funds. 451 U.S. at 12–13, 17. By contrast, the equal access provision is a Medicaid state plan requirement, represents requirements that states "must" meet in order to receive federal funding, and falls squarely within the purview of 42 U.S.C.§§ 1320a-2 and 1320a-10. Moreover, the Ninth Circuit's invocation of *Blessing* and *Gonzaga* as a reason to ignore the terms of these provisions is somewhat bewildering. Those cases were decided after *Artist M.* and, as such, are not supposed to be the basis for private right of action decisions in Social Security Act cases. Rather, pre-*Artist M.* holdings like *Golden State Transit* and *Virginia Hosp. Ass'n* are to be controlling. Equally important, the Ninth Circuit's decision condemns these statutory commands to the status of dead letter law. It is as if Congress had never passed them.[15]

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[15] The Ninth Circuit's decision on this point also seems to be at odds with holdings of other Circuits using these provisions as a basis for finding a private right of action under other Medicaid Act provisions. *E.g., S.D. ex rel. Dickson v. Hood*, 391 F.3d 581, 603 (5th Cir. 2004) (right to early and periodic screening, diagnosis, and treatment services under 42 U.S.C. § 1396a(l)(10)(A)); *Rabin v. Wilson-Coker*, 362 F.3d 190, 201-02 (2d Cir. 2004) (right to Medicaid benefits under 42 U.S.C. § 1396r-6).

Congress has the right and the discretion to decide whether and how its enactments should be construed in terms of whether they afford private rights of action either on their own or under the Supremacy Clause or § 1983, and it has various means at its disposal to do so. Here, Congress has unequivocally indicated that Social Security Act cases involving state plan requirements must be reviewed under pre-*Artist M.* precedent. The Ninth Circuit failed to do that either here or in *Sanchez*.[16]

It should also be emphasized that, although *Amici's* brief has focused principally on § 1983, existing case law at the time 42 U.S.C. §§ 1320a-2 and 1320a-10 were enacted strongly suggests that the Supremacy Clause was a basis for private enforcement of federal law. *E.g.*, *Shaw v. Delta Airlines*, 463 U.S. 85, 96 n.14 (1983). *See* Br. For Respondents at 7-10, 21-27, 29-41 and Appendix thereto. The congressional directives in these sections that pre-*Artist M.* case law be used to adjudicate private rights of action in Social Security Act cases make no distinction as to the particular avenue for private enforcement. Thus, they apply with equal force to the Supremacy Clause. As such, the state of the case law in 1992 as to the Supremacy Clause and private rights of action is an independent basis for affirming the Ninth Circuit's ruling in this case. In short, under the terms of 42 U.S.C., §§ 1320a-2 and 1320a-10, the Supremacy Clause affords a

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[16] With one exception, the Petitioners and their supporting *amici* in this case do not cite or discuss 42 U.S.C. §§ 1320a-2 and 1320a-10. The brief of the United States does so (Br. For United States as Amicus Curiae Supp. Pet'r's 29–30), but is predicated on the assumption that there is no § 1983 right of action here. That assumption conveniently skirts the analysis required by those provisions and effectively renders them a nullity.

private right of action for the enforcement of the equal access provision by Medicaid providers.

Consequently, if—contrary to *Amici's* position that this case should be affirmed on the basis of the Ninth Circuit's decision—the Court decides either that the Supremacy Clause does not afford a private right of action or that it is not inclined to decide that issue, it should remand the case to the Ninth Circuit. This would permit full-blown briefing and oral argument on the issues under 42 U.S.C. §§ 1320a-2 and 1320a-10 and avoid the Court having to perform a first blush analysis of its own. By doing the latter, this Court can also follow its time-honored tradition of refraining from reaching issues involving constitutional questions when that can be averted. *E.g.*, *Califano v. Yamaski*, 442 U.S. 682, 692–93 (1979).

C. Prudential Considerations Also Suggest That Private Right Of Action Standards Erected After Passage Of The Legislation In Question Should Not Be Employed

Part of Congress' motivation in enacting 42 U.S.C. §§ 1320a-2 and 1320a-10 may have been an uneasiness that its handiwork was being judged by adjusted, modified, or entirely new private right of action standards enunciated or created judicially long after the legislation in question had been enacted. Regardless of the existence of these provisions or their implications, this Court could—on its own and without congressional direction—apply evolving principles prospectively only rather than retroactively, using instead the tenets that were in place at the time. To do otherwise ascribes a clairvoyance to Congress that it simply does not and cannot have. For example, if Congress passed a particular provision in 1980,

Congress may rightly be charged with the responsibility for knowing the private right of action case law and tests in place at that time.[17] It cannot be held accountable for foreseeing new or different standards developed years or decades later. Such a course of action is the best means of giving full voice to the real intent of those who actually framed and passed the legislation.

CONCLUSION

The Court should affirm the Ninth Circuit and hold that the Supremacy Clause affords Medicaid providers with a private right of action to enforce the equal access provision. However, if the Court either decides the Supremacy Clause issue in the negative or believes that it should avoid deciding that issue at this juncture, this case should be remanded to the Ninth Circuit for consideration of the question of whether the Respondents have a private right of action to enforce the equal access provision in light of 42 U.S.C. §§ 1320a-2 and 1320a-10.

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[17] In this case, for instance, the "efficiency, economy, and quality of care" component was enacted in 1968 in the Social Security Act Amendments of 1967, Pub. L. No. 90-248, § 237, 81 Stat. 821 (1968). The language relating to sufficient enlistment of providers to assure equal access was added in 1989 as part of the Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, § 6402(a), 103 Stat. 2106, 2260. Significantly, HHS has never promulgated final regulations relating to the equal access provision, though it did issue proposed regulations more than three and a half years ago. 76 Fed. Reg. 26,342 (May 6, 2011). Nor has HHS ever modified or amended its regulations to reflect the repeal of the Boren Amendment even though that occurred 17 years ago. 42 C.F.R. §§ 447.205-.256. This is telling evidence that HHS should not be entrusted with exclusive enforcement authority as to the Medicaid Act and its rate-setting standards.

Respectfully submitted,

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